

June 2, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-03-0975-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 52 year-old female who sustained a work related injury on ___. The patient reported that while at work she tripped and fell landing on her outstretched right hand. The patient was evaluated in the emergency room and treated with medications. She was then treated conservatively with therapy and more medications. The patient has undergone X-Rays of the right wrist, bone scan of the hands and an MRI of the lumbar spine that showed multi-level degenerative disc disease with disc desiccation and bulging disc at multiple levels. The diagnoses for this patient included effusion of joint, spasm of muscle, myalgia and myositis and sprain/strain of hip and thigh.

Requested Services

Purchase of BMR NT2000 Neuromuscular Electrical Stimulator.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 52 year-old female who sustained a work related injury to her right hand and lumbar spine on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included effusion of joint, spasm of muscle, myalgia and myositis and sprain/strain of hip and thigh. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included therapy and oral medications. The ___ chiropractor reviewer indicated that there is no objective evidence that using the requested unit provides any benefit to the patient. The ___ chiropractor reviewer explained that this patient's injury is ___ months old. The ___ chiropractor indicated that the patient used the requested unit for at least 4 months already. The ___ chiropractor reviewer also indicated that there is no documented reports of how effective the unit was and whether care would be cut down or eliminated because of its use. Therefore, the ___ chiropractor consultant has concluded that the requested purchase of BMR NT2000 Neuromuscular Electrical Stimulator is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of July 2003.